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A qualitative examination of social identity and stigma among adolescents recovering from alcohol or drug use

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ABSTRACT

Introduction: Alcohol and other drug (AOD) use disorders are stigmatized conditions, but little is known about youth's experience of this stigma, which may threaten their developing social identity and recovery process. This study investigates youth's perceptions of AOD use-related stigma in the context of their social identity.
Methods: This study uses data from 12 youth (ages 17–19) who were in recovery from problematic AOD use. Participants completed a Social Identity Mapping in Addiction Recovery (SIM-AR) exercise, in which they created a visual map of their social groups, and semi-structured interview, in which participants were asked about their experience creating their SIM-AR and reflections on their social network. SIM-AR data were descriptively analyzed, and interviews were thematically analyzed for instances of stigma.
Results: Using stigmatizing terminology, participants expressed some stigmatizing attitudes towards themselves and others in their network who used substances and perceived both positive and negative reactions from those who knew about their disorder. Findings suggest that youth may experience some internalized stigma and perceive stigma from others in their social networks, which may be a barrier to the development of a healthy social identity and engagement in recovery supports.
Conclusions: These findings should be considered when seeking to engage youth in treatment and recovery programming. Despite the small sample, the findings suggest the importance of considering how stigma may influence adolescents' treatment and recovery experience in the context of their social environment.

1. Introduction

Alcohol and other drug (AOD) use disorders are highly stigmatized conditions (Kelly et al., 2016; Lang & Rosenberg, 2017). Stigma occurs when an individual or group is considered to have a devalued trait that can lead to social exclusion, discrimination, and negative consequences, including lowered self-esteem, identity-related stress, and worse health (Goffman, 1986; Hatzenbuehler et al., 2013; Link & Phelan, 2001; Major & O'Brien, 2005; Pachankis, 2007). People with an AOD use disorder, or in the process of reducing substance-related behaviors and improving general well-being (i.e., recovery), may perceive, experience, and internalize stigma (Luoma et al., 2007; Pescosolido & Martin, 2015; The Betty Ford Institute Consensus Panel, 2007). Approximately 60% of adults in AOD treatment reported perceiving stigma, which was associated with increased secrecy about their disorder, and over half of adolescents surveyed would feel ashamed if their friends knew that a person in their life used substances (Adlaf et al., 2009; Luoma et al., 2007). Stigma can prevent individuals from seeking treatment, worsen recovery outcomes, result in poor mental health, and can act as a barrier to developing positive relationships (Adams & Volkow, 2020; Crapanzano et al., 2018; Luoma et al., 2007; Pachankis, 2007). Given their developmental phase, adolescents may be highly vulnerable to health-related stigma (Earnshaw et al., 2022; Ferrie et al., 2020; Heary et al., 2014).

Although there is a growing body of research on stigma among adults in recovery (Brown et al., 2022; Crapanzano et al., 2018; Luoma et al., 2007; Sibley et al., 2020), less is known about stigma in adolescent recovery. Recovering adolescents likely view their recovery journey differently from adults (Earnshaw et al., 2018; Gonzales et al., 2012). Recovering adolescents are often in the transitional phase of developing

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sober relationships and a recovery identity (Best et al., 2016) and in working towards achieving key developmental goals (i.e., graduation, college, employment; Schoenberger et al., 2021). This manuscript uses a stigma lens to explore recovering adolescents' conceptualization of their AOD use disorder experience and the AOD use of others in their network.

1.1. Theory of addiction-related stigma

In their seminal review of the stigma literature, Pescosolido and Martin (2015) suggest that stigma has experiential and action-oriented aspects. Experiential stigma, which encompasses how stigma is experienced, includes perceived stigma by the stigmatized group, instances of enacted stigma towards members of the stigmatized group, and endorsed stigma, which is agreement with negative stereotypes about a stigmatized group. Action-oriented stigma refers to how stigma is given and received and includes internalized stigma, which is stigma internalized by members of a stigmatized group (Pescosolido and Martin, 2015). Substantial evidence indicates there is a great degree of external (perceived and enacted) and internalized stigma towards and among individuals with addiction, often sustained by the belief that individuals chose to engage in problematic substance use (Kelly et al., 2016; Luoma et al., 2007; Major & O'Brien, 2005). Enacted stigma appears in everyday conversation and is represented in terms or phrases that imply control or fault (e.g., "addict," "drug user," "abuser," or language that implies that people are "clean" or "dirty" based on their abstinence status; Ashford et al., 2018; Ashford et al., 2019a; Kelly et al., 2016; Kelly & Westerhoff, 2010).

1.2. Addiction-related stigma in adolescence

Research suggests that adolescents may uniquely experience the stigma components described by Pescosolido and Martin (2015). Adolescents may endorse stigma towards people who use substances but tend to endorse less stigma when they use substances themselves (Adlaf et al., 2009). Yet, adolescents with AOD use may perceive stigma from others at higher rates (Earnshaw et al., 2018). Adolescence is a prime period of social identity development and because addiction stigma persists even during recovery, it can threaten youth's social identity and identification with recovery groups (Major & O'Brien, 2005). During adolescence, youth often experiment with different identities and mold their behavior to fit the norms of groups to which they want to belong (Erikson, 1968; Marcia, 1966). To feel socially accepted, adolescents may not want their identity to be defined by an AOD use disorder, instead framing their identity with other positive traits (Ferrie et al., 2020; Heary et al., 2014; Klimstra et al., 2010). Thus, recovering adolescents may separate themselves from a "using" identity by removing friends who use substances (Adlaf et al., 2009; Best et al., 2016; Gonzales et al., 2013; Schoenberger et al., 2021).

1.2.1. Social support in youth recovery

Perceived stigma also affects the development of close social bonds, as adolescents may avoid disclosure about their recovery experience for fear of being seen as "abnormal" among peers (Earnshaw et al., 2018; Pescosolido & Martin, 2015). Social support may mitigate the experience of stigma and engaging in recovery-supportive groups can facilitate the transition to a recovery identity (Best et al., 2016). However, youth may initially struggle to form new relationships with recovery groups (Nash et al., 2019), which can be isolating. Perceived stigma during this time may also leave youth feeling vulnerable, less likely to engage in supportive services, and stall their social identity development (Heary et al., 2014).

1.3. Study aim

Given the lack of research on stigma among adolescents with an AOD use disorder, and the variety of potential negative outcomes that could arise from addiction-related stigma, this study explores how adolescents describe their recovery experience and the substance use of others in their social network. Using Pescosolido and Martin's (2015) organizing framework of experienced, perceived, and internalized/endorsed stigma, we present themes related to the stigma experience of youth in recovery. As social support may mitigate the consequences of stigma, social support that adolescents reported receiving in the face of stigma is also captured.

2. Methods

The data analyzed in this study is from a pilot study (see Jurinsky, Cowie, Blyth, & Hennessy, 2022 for further description) assessing the feasibility of using Social Identity Maps in Addiction Recovery (SIM-AR; Beckwith et al., 2019) with youth. A SIM collects characteristics of participants' social networks and is a visual representation of one's social network and its characteristics. It has been used among a variety of populations (e.g., see Haslam et al., 2008, 2019; Jetten et al., 2010) although the SIM-AR has primarily been used in adults with AOD use disorder (Beckwith et al., 2019; Mawson, Best, Beckwith, Dingle, & Lubman, 2015; Best et al., 2014; Haslam et al., 2017). The MGH IRB approved the overall study protocol, which was pre-registered on OSF, but the stigma-related analysis reported here was not preregistered and should be considered exploratory. Further study details and qualitative coding excerpts analyzed can be found on our OSF page (https://osf.io/8yuwz/?view_only=9e777f91def44511838be79904397df4).

Eligible participants were youth ages 12–19 who reported being in recovery for AOD use and/or seeing a provider for their AOD use. We used a purposive sampling strategy to recruit youth to pilot the SIM-AR from relevant sites (i.e., recovery high schools, treatment centers) using emails, flyers, and staff referral (03/19/2021–01/28/2022). Participants were told this was a study to pilot a new data collection tool and we wanted to learn about how their social networks influenced their recovery. Due to the COVID pandemic, recruitment was challenging, and most study participants were from recovery high schools (RHS: schools for recovering youth), likely due to ongoing collaborations with school staff who referred participants and coordinated onsite data collection. All participants provided informed consent, and guardian consent was obtained if the participant was under 18.

Each study visit was remote, conducted over Zoom, and consisted of the facilitated completion of a SIM-AR (Beckwith et al., 2019), an interview where participants reflected on their completed SIM-AR, and a brief demographic survey (i.e., age, gender [female, male, non-binary, other], race, ethnicity, and length of time in school/treatment).

2.1. Social identity map

To create a SIM-AR, participants are asked to identify their current social groups and then asked a series of questions about these groups and group characteristics. They use sticky notes, markers, and color dots to complete the SIM-AR in response to the questions (see Appendix A, Table A1 for all items collected on the SIM-AR).

Participants decide on a label for each of their social groups, which we also analyzed. In this study, we devised a list of terms that research has indicated evokes stigma, such as "addict," "alcoholic", "being clean/dirty" (i.e., see Ashford et al., 2018; Ashford et al., 2019a, 2019b; Kelly & Earnshaw, 2021). We then categorized the label participants provided for each group on their SIM-AR as stigmatizing or non-stigmatizing. Stigmatizing labels were descriptively analyzed and are presented in the results as part of stigmatizing language use.

2.2. Interviews

The interviews followed a semi-structured interview guide, and participants were asked to reflect on their completed SIM. For example, they were asked to consider what their SIM tells them about themselves,

Table 1
Participant Characteristics and Stigma-Related Coding Results.

Participant ID	Gender	Age	Racial/ethnic heritage	Map labels used for groups	Interview terms or phrases used	
					To describe self in relation to substance use behaviors	To describe others in relation to substance use behaviors
3	Male	19	Hispanic and White	Drug addict, family, sober friends, church friends	Addict, recovering addict, "I have like nine months clean"	Drug addict people, drug addicts, addicts, drug addict friends, "It's nice to be like, alright I know this person is clean"
5	Male	18	White	Family mom and grandparents, drug friend, recovery group, work, friends	My addiction	Drug friends, recovering alcoholics
6	Male	Not reported	White	Extended family, close friends, acquaintances, immediate family, recovery people		
7	Male	18	White	Sober house, family, customers, drug user friends[1]		
8	Male	17	White	Family, close friends, drug friends, recovery group		Drug friends, addiction, alcoholics, drug users, people in active addiction
1	Male	18	African American, American Indian, Asian, Hispanic, White	Family/friends, [RHS] Work, Doc/therapist		
2	Male	Not reported	African American	Friends at school, progressivists, musicians, LGBTQ+, family		
4	Female	Not reported	Not reported	Not visible[2]	"I had an issue" and "if I want to get clean, it has to be for me"	
9	Female	18	Hispanic and White	Family, close friends, people at college, people at school, recovery network		"People in my life that are like actively in addiction"
10	Male	17	White	Family, social media, school, therapy, meetings, work, friends		Heavy drinkers, heavy users of both alcohol and drugs, casual drug users, alcoholics, heavy drug user, stoner
11	Male	18	White	Family, close friends, work friends, "drug friends", recovery		Drug friends, friends who use
12	Male	18	White	Family, work, friends		People who have drug and alcohol problems, people with substance use issues, friends who are clean

Note. This table displays participant demographics and the words participants used in their interviews and on their Social Identity Maps to describe their own AOD use and the AOD use of others.

[1] This participant only used traditionally stigmatizing terminology on his Social Identity Map and not during his interview.

[2] This interview was video-recorded and transcribed, but a clear copy of participant's map and survey data are missing because of procedures we used in the early phases of the project. In the early phase of the project, participants were asked to mail responses back in a postage-paid envelope, which resulted in missing data for this participant as we did not receive back the package.

their recovery journey, and supports (see OSF/Appendix A for prompts). Interviews were recorded, professionally transcribed, checked by a study team member, and uploaded into an NVivo database for data management (V1.0, March 2020; QSR International Pty Ltd, 2020).

2.3. Analysis

Analysis was initiated as a deductive coding approach but moved to an inductive approach during data analysis for this manuscript (Corbin & Strauss, 2008). One researcher reviewed the transcripts and developed a codebook based on the four domains of adolescent recovery capital (Hennessy et al., 2019): human, financial, social, and community. Several interviews were reviewed, and the four study team members met to discuss the codebook and develop additional themes focused on the social aspects of recovery. As the study team applied the broader code of social aspects of recovery to the transcripts, the research team also identified use of stigmatizing terminology and reports of stigmatizing experiences and created a new child code of *stigma* that captured the three dimensions of focus in this study: (1) stigmatizing attitudes, (2) perceptions/experiences of stigma from others, and (3) stigmatizing terminology used by participants. The team iteratively analyzed the data using a constant comparative approach and met regularly to identify and come to consensus on the stigma-related coding process (Corbin & Strauss, 2008; Lincoln & Guba, 1986). Using the stigma framework of Pescocolido & Martin (2015), we categorized participant's stigmatizing terminology and expression of stigmatizing attitudes as internalized and/or endorsed stigma, and we categorized perceptions/experiences of stigma from others and expression of stigmatizing attitudes from others as perceived stigma.

3. Researcher positionality and trustworthiness

Our diverse team represented current placements of clinical internship, faculty, and undergraduate and graduate students with varying degrees of research experiences. The faculty member leading the project and conducting the majority of the interviews had conducted extensive mixed methods research with recovering youth and youth-serving organizations. Two of the authors were involved in the data collection, while the other two only had access to the transcripts. To increase the trustworthiness of the analysis (Lincoln & Guba, 1986), the team reviewed the transcripts for negative cases (i.e., participants who may not have reported stigma or used stigmatizing language) and discussed how those cases might have differed from other participants.

4. Results

Of the 12 participants, 10 were male, and the average age was 17.75 years old (SD = 0.62). Most (n = 11) were currently attending an RHS. See Table 1 for participant demographic data. Across interviews, participants often used stigmatizing terminology to describe their own AOD use suggesting some internalized stigma, some described perceiving stigma, and others described receiving support from social network

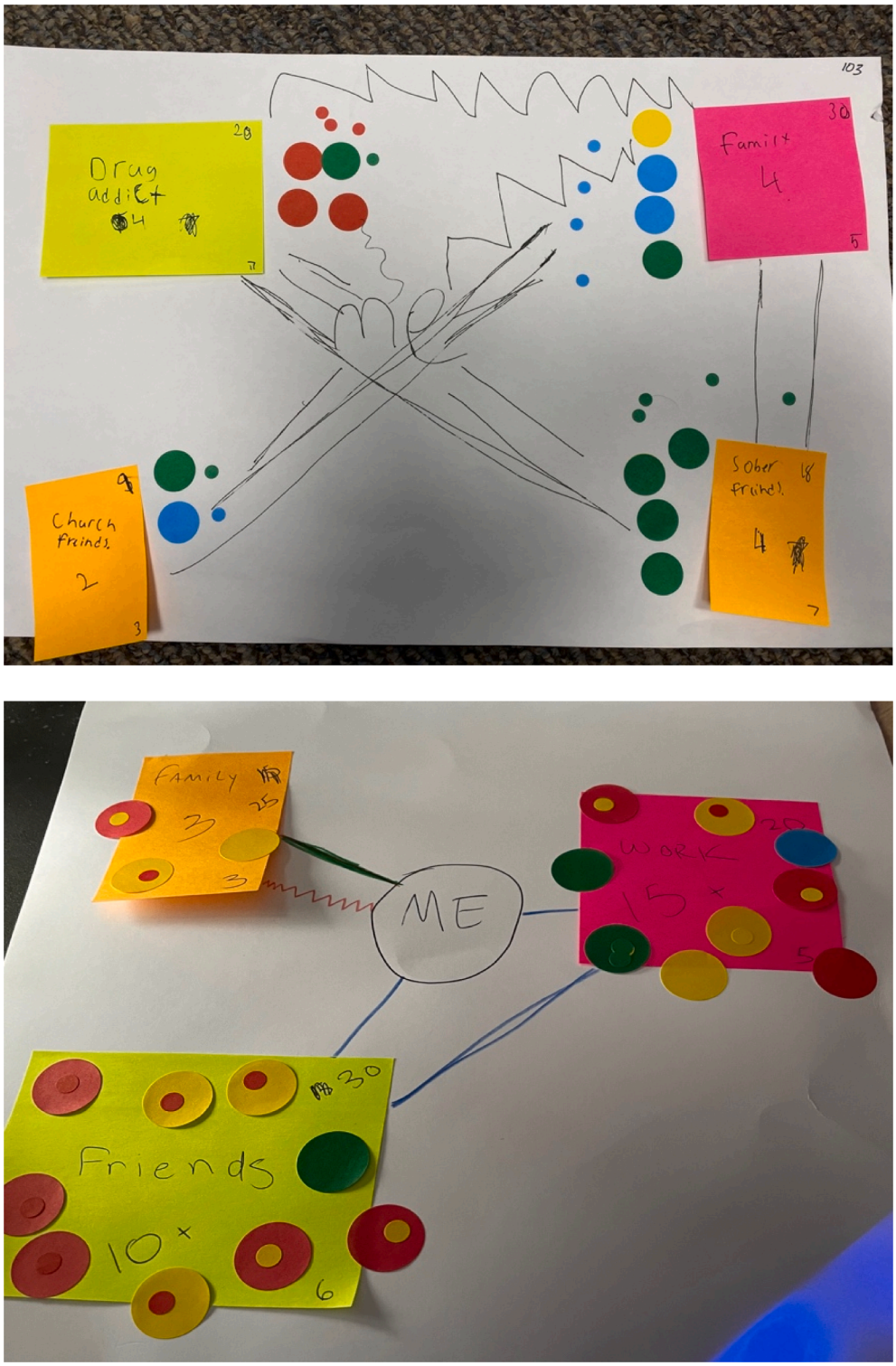

Fig. 1. *Example Social Identity Maps with and without Stigmatizing Language* The first Social Identity Map depicts a male participant's social groups, one of which he named with traditionally stigmatizing terminology, "Drug Addict" *(#3, Male, 19)*. The second Social Identity Map depicts the social groups of a male participant who did not use traditionally stigmatizing terminology, although a significant number of members in his social network used alcohol and other substances heavily, as shown by the red dots (*#12, Male, 18*). (For interpretation of the references to color in this figure legend, the reader is referred to the web version of this article.)

members who understand AOD use disorder or who are in recovery.

4.1. *Internalized Stigma/Self-stigma*

Overall, 75% of participants used stigmatizing language in their map or interview to describe their own or others' AOD use. Two of these male participants, referred to themselves using stigmatizing language, for example by labeling themselves an "addict" and a "recovering addict" (*Sp#3*). Three of these participants used stigmatizing language to distinguish between those who were abstinent and those who were not by describing themselves or others in recovery as "clean".

Seven of the 12 participants used terms to suggest that others without mental health and substance use issues were "normal" or "healthy" compared to themselves. When referencing being around his recovery group, *Sp#10* reflected that it was "exhausting" being with "other sick people". *Sp#3* reflected that he felt a stronger connection to "drug addict people or recovery people" versus "normal people… everyday people". Participants also gave examples of attributes they felt

differed between themselves and those they considered normal, and they criticized personal behaviors that they attributed to their AOD use. For example, *Sp#3* reflected that "Emotions with addicts is hard, too. We don't understand what emotions are". *Sp#5* discussed wanting a romantic relationship, a typical developmental step in adolescence, but blamed his AOD use for not being able to "hold onto" one. *Sp#7* expressed self-criticism about his use and the implication that his disorder was due to poor choices, stating, "I'm not a little kid anymore, I can't do whatever. I got to grow up".

Alternatively, participants who did not report perceiving stigmatizing experiences did not use stigmatizing language to describe the AOD use of themselves or others. These participants instead used terms related to sobriety or recovery more broadly to describe their own use history, such as by "being sober" (*Sp#1*), identifying as part of a recovery group (*Sp#6*), or reflecting that the shift to a recovery identity was a result of joining recovery spaces and making sober friends (*Sp#2*).

4.2. Endorsed stigma

When discussing others in their network, a third of participants used traditionally stigmatizing language in both the interview and their SIM-AR, such as "drug addict," and "drug user," three participants used stigmatizing language only in their interview, such as "alcoholic," and one participant using stigmatizing language only on his SIM-AR (See Table 1 and Fig. 1 for examples of language use on maps). *Sp#3* reflected on how seeing his groups on the SIM-AR made him feel: he listed negative words for the groups who used substances, "like drug addicts, I'd put, anger, depression, sad, weak" and called his church friends "normal".

Twenty-five percent of participants perceived other people in their network who used substances as negative influences that they needed to remove and often used stigmatizing language to describe these individuals. For example, *Sp#8* referred to all his pre-recovery friends being "drug users" and "dealers". He also expressed relief that he does not "have much addiction in my immediate family" despite "alcoholics" in his extended family. Some participants also described other people in their network who struggled with substance use as "not healthy or good" for them (*Sp#9*) or getting in the way of living "a somewhat normal life" (*Sp#10*). Yet, a third of participants who felt that these friends could be a risk for their own recovery also felt strongly connected to them.

4.3. Experiences of stigma or support

4.3.1. Perceived and received stigma

Several participants discussed that certain members in their social network lacked understanding of their AOD use recovery, including family members. *Sp#3* reflected that it was harder for his family "to look at me than it is for some of my other people I talk to". *Sp#10* reflected, "My parents don't understand, because they… aren't alcoholics. They aren't drug addicts. They haven't been through recovery or treatment".

Others experienced a lack of support and potentially stigmatizing experiences from their peers. Many participants reflected that they had fewer friends since entering recovery and felt isolated at times. Participants also discussed whether they shared their AOD use disorder status with their peers. For example, *Sp#10* shared that he does not "openly walk around, and I'm like, 'Yeah, I'm sober and I'm in recovery'" because "nobody really needs to know". Another experienced criticism of recovery and reflected on the need for broader de-stigmatization of addiction: "People need to realize, like, it's more than just someone choosing to do the drugs at first… it's like a bad nightmare that just keeps going on every day" (*Sp#3*).

4.3.2. Perceived support

A third of participants reflected that they felt supported by those who either understood their experience with AOD use disorder and/or who also used substances. One male acknowledged that his friends with AOD use disorder understand his experience uniquely:

> *That's why I think I connect* to [drug addict friends] *more, because there's just no judgment. And like, when I go into like a normal… like church, for instance, I walk in, I can't just be like, 'yeah, man, I want to shoot up today'* (*Sp#3*).

Another noted that his family members were supportive and some even were "recovering alcoholics" so they knew "what it's like in some ways" (*Sp#5*).

5. Discussion

In this study of 12 recovering youth, many participants described stigmatizing attitudes towards themselves and others, which could represent internalized and endorsed stigma, perceived stigma from others who they believed did not understand their disorder, and, in the face of stigma, felt supported by people in their network to whom they felt they could disclose their status. These findings are in line with theory suggesting that people with AOD disorders may perceive and experience stigma and that they may internalize or endorse this stigma (Pescosolido and Martin, 2015).

Some terms used by participants, including "addict" and "alcoholic", are reflective of and can increase stigma (Ashford et al., 2018; Ashford et al., 2019a, 2019b; Kelly & Earnshaw, 2021). When participants use these terms, they may be implicitly endorsing stigmatizing views and/or expressing internalized stigma. Research suggests that individuals in recovery may continue to have negative associations with terms such as "addict," but this may be because they no longer identify with substance use (Ashford et al., 2019b). Participants expressed both negative and positive perceptions of others who used substances, which may also reveal how they feel about themselves. This may also reflect a distancing from or acknowledgment of a shared identity (Best et al., 2016). Studies have shown that adolescents conceptualize their substance use as a choice, as some participants did, but that they may also express autonomy to act in their recovery (Gonzales et al., 2012, 2013; Schoenberger et al., 2021). In line with the young adult literature, some youth in this study indicated that they view recovery as the return to being a "normal" teenager by participating in age-appropriate activities, such as finding a job or starting college (Schoenberger et al., 2021).

Some participants also expressed endorsed stigma towards social connections in their networks who use substances and discussed the need to distance themselves from these friends, who they acknowledged may be risky to recovery. Yet, they also expressed feeling understood in these relationships. This remains a common challenge for adolescents in recovery, who experience lower levels of stigma and isolation in the company of friends who use substances but put themselves at risk of continued use (Adlaf et al., 2009; Gonzales et al. 2013; Palamar et al., 2013). Research suggests that the creation of a new, recovery or sober friend group can facilitate the transition into recovery (Adlaf et al., 2009; Best et al., 2016), but this is not easy for adolescents to do. Thus, while youth early in recovery may have distanced themselves from using friends, without forming a recovery identity they may feel a lack of social connection with others and be more prone to experiencing stigma.

In this sample, participants sometimes used disclosure to form new connections in their recovery programs or with family and friends who understand the disorder. However, participants also perceived and received enacted stigma from others. Similar to previous research suggesting that adolescents are conscious of the potential stigma or support they might receive after disclosing their AOD use disorder status, participants noted that some relatives and friends did not understand AOD use disorders or passed negative judgments on recovery (Earnshaw et al., 2018). Yet, four participants expressed receiving support in their recovery as a direct result of self-disclosure. Supportive responses received in the face of stigma may be opposite to what the model of stigma suggests. Social support within one's recovery network can counter the detrimental effects of stigma while increasing engagement

in treatment and recovery supports (Dobkin et al., 2002; Hatzenbuehler et al, 2013). Thus, these findings should be considered when assessing safe places for youth to freely disclose their status and form a new social identity (i.e., Recovery High Schools), as youth should have ample opportunities to disclose to others who are likely to be accepting (Ferrie et al., 2020; Pachankis, 2007). Recent work has also introduced novel approaches to reduce stigma, for example through community drama or in clinical settings, which are promising approaches for future work with recovering youth (Bielenberg et al., 2021; Hennessy et al., 2023; Khenti et al., 2019).

When working with youth, we recommend that addiction providers ask them about how they prefer to talk about their experience and use their responses as a guide for how they engage youth and advertise their programming. In addition, the finding that recovering youth feel more understood by peers who engage in substance use might be an important insight for their caregivers who may not understand why their youth continually interacts with others who are viewed as "risky".

6. Limitations

As the data is drawn from a pilot study, the sample size is relatively small; yet, research suggests that an average of 12–13 participants is needed for saturation (Hennink and Kaiser, 2022). As well, when considering the concept of information power, this study's purposive sampling strategy included youth primarily attending a specific type of addiction recovery support (RHS) and who identified as White and non-Hispanic, suggesting there may be adequate power for the questions examined (Malterud et al., 2016). These themes are worth examining further in a larger population, as a larger and more diverse sample could help us to better understand the stigma experience among all recovering youth. Future research should ask direct questions about recovering youth's experience of stigma, as participants were not directly asked about their experience of stigma in this study. Finally, we provided participants with an example SIM-AR legend from previous research (Beckwith et al., 2019) to help with their map creation and it included a social group titled "drug friends". Although we encouraged youth to create their own group labels, some participants may have been influenced by this example.

7. Conclusion

Recovering youth may experience internalized stigma coupled with a desire to separate themselves from a stigmatized group engaging in AOD use to return to normalcy. Despite this tension, many participants identified people and places of support. Findings suggest that recovering youth benefit from having social supports who understand their experience and support their recovery efforts, such as those that are provided in recovery high schools, alternative peer groups, young people's meetings, or recovery clubhouses. Importantly, these supports can mitigate isolation and stigma. The heterogeneity of reflections during the SIM-AR activity suggests that it is necessary to consider each adolescent's unique experience as they enter recovery and seek to develop their social identity.

Author Disclosure

Role of Funding Sources

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Contributors

Sophia Blyth and Emily Hennessy conceptualized the idea for the study and were involved in the validation, investigation, and data curation. Emily Hennessy designed the methodology, supervised the creation of this paper, and acquired the funding for the study. All authors contributed to the formal analysis and to the review and editing of the manuscript. Sophia Blyth visualized the data and wrote the first draft of the manuscript, and all authors contributed to and approved the final manuscript.

Table A1
Items collected on SIM-AR.

Item	Range, if applicable
Social groups in person's network, labeled with group name	
Days spent with each group	(0–30)
Importance of each group	1–3 (1 = lowest; 3 = highest)
Level of identification with group	1–7 (1 = low; 7 = high)
Number of group members	
Alcohol use of group members	Heavy, casual, non-use, in recovery, unknown
Substance use of group members	Heavy, casual, non-use, in recovery, unknown
Conflict	None, low, high
Commonality	None, some, a lot

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Data availability

The link to relevant data hosted on our Open Science Framework project page is provided in the manuscript.

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Author note

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Appendix A

SIM-AR Creation and Data : See Table A1 for the SIM-AR instructions and variables collected.

Semi-Structured Interview Prompts

When you look at your finished map, what do you see, and what does it make you consider about yourself?

Did you learn anything new about your relationships and social networks through creating your map?

Do any of the groups have a positive influence on your life?

If so, which ones and how?

Do any of the groups have a negative influence on your life?

If so, which ones and how?

What does your map tell you about the recovery journey you are on?

Did anything in your map surprise you?

If I had asked you to complete a social identity map 6 months ago, do you think your map would look different?

If YES, how so?

If you think ahead to 6 months from now, what would you like your map to look like?

And what would you not want it to look like 6 months from now?

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